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ABSTRACT

The paper reports on a program to change behaviors of six blind multihandicapped adolescents with severe behavior disorders at the New York Institute for the Education of the Blind. Examples are drawn of the program's effects on a 17 year old male, Joe. Program principles include reduction of stressful situations for the students, expansion of receptive and expressive communication skills, and a 1 to 1 staffing ratio. Target behaviors were identified and a behavior plan developed for each student. Implementation of the program for 3 months has led to reduction in frequency and severity of Joe's tantrums. Appended are sample forms used for charting behaviors, suggested guidelines for developing a behavior plan, and a treatment plan for dealing with Joe's tantrums. (DB)

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PROGRAMMING FOR BLIND-MULTIHANDICAPPED ADOLESCENTS WITH SEVERE BEHAVIOR DISORDERS

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PROGRAMMING FOR BLIND-MULTIHANDICAPPED ADOLESCENTS WITH SEVERE BEHAVIOR DISORDERS

By Linda Lanting Gerra

The New York Institute For The Education Of The Blind has provided educational programming for low-functioning blind multi-handicapped students for the past 10 years. Recently, a small number of students have emerged displaying difficult-to-manage behaviors, i.e. hitting, scratching, choking head-banging, pinching, etc. These behaviors may be self-abusive or aggressive. When these behaviors occurred, it often required both the teacher and an aide to protect the student or others from injury and to calm the student. Until recently these students were "manageable" because they were small in stature.

Now, in mid-adolescence 6 students present a challenge to behavior management, and a special program was instituted this year in an attempt to meet these students' unique needs. There are 2 boys and 4 girls in the group, ages 16 and 17. A wide range of disabilities are present within the group including total blindness (5 students), profound hearing loss (6), retardation (6), cogenital heart disease, congenital rubella, microcephalia, scoliosis, bone and skeletal anomolies. They are functioning at a 6-10 month level in communication and socialization. Although their motor skills and basic self-care skills are slightly higher developmentally (12-20 months), the students are not independent and for most educational activities require a 1-1 staff-student ratio. Due to the severity of their disabilities, their primary modalities for learning are tactual and olfactory.

Four out of six students have spent part of their early years in a state institutional facility. Joe, from whose case I will draw examples throughout this paper, is currently 17 years old. It is important to note his family history in order to gain a total picture of Joe and in an effort to better understand possible causes of his behavior. Joe was born 8-20-64 with congenital rubella. He was 3 lbs, 1½ oz. at birth. His mother had a 6-month pregnancy and a normal delivery. He was hospitalized until he was 3 years old. The reason for the hospitalization was not clear from the records. He occasionally came home on weekends or for one-two-month periods. He was transferred to a state institution at a young age, and it is unclear as to whether he lived at home at all. He was transferred to the New York Institute For The Education Of The Blind on November 9, 1976.

Previously these 6 students were grouped in two different ways:

1. Placing one student in each class, thus disrupting the other students and requiring the attention of both staff during periods of disruptive behavior.

2. Grouping the students together, but without an increase in staff. This resulted in staff proceeding from one crisis to another, educational programming could not occur, and it was a drain on staff time and energy.

The third approach, which is in its seventh month, will be described here as it developed from September until March. The primary goals of the program are to modify and improve the students' behaviors so they can return to a regular classroom situation within the multi-handicapped program. The program recognizes the need for a consistent management approach drawing from a variety of behavioral therapy techniques. This consistency is attained in part by designing and following specific "behavior plans" for each student. Data is taken on an on-going basis to enable staff to clearly see progress or regression and thus modify behavior plans accordingly.

On the basis of past experience with severely acting-out students, it is felt that the program be based on activities which are pleasurable and motivating whenever possible. Every effort is made to reduce stressful situations and to avoid placing undue pressure on these students until the behaviors are under control. A severely multi-handicapped student may not have learned how to deal with stress and frustration, and this may be a factor in causing disruptive behavior.

A second emphasis of the program is an attempt to expand communication skills of these students both receptively and expressively. These severely multi-handicapped children are extremely limited in their communication skills. They are unable to express their needs and do not understand what they are expected to do or what is asked of them. This often leads to confusion, misunderstanding, and finally frustration which may result in maladaptive behaviors.

Total communication (signing and speaking) is employed as the method of communication. Concrete objects are also presented to the students as a symbol of an activity (i.e. towel to indicate swimming). The students are given more time to do what they are asked, and a sign or cue may be repeated 8-10 times before the adult finally manually manipulates the students through the desired action.

The staffing pattern for this group is, of course, extremely important. We were fortunate enough to arrange a 1-1 staffing ratio. There is 1 teacher, who coordinates all aspects of the program and 5 teacher-aides. This staffing pattern enables the group to provide the consistency needed to carry out an intense behavior management program. At times 3, 4, or 5 staff may be needed to restrain or manage a student to prevent him/her from hurting himself or other students and staff. Since these students lack basic skills and independence, a 1-1 ratio is also required for most of their daily activities. In fact gross motor activities may require 2 staff people putting students through the movements.

An adequate number of staff, however, does not automatically solve the problem of staff morale in this specialized and extremely intense situation. Working with students whose daily behaviors range from regurgitation to smearing feces as well as wide range of self-abusive and aggressive behaviors (See Example I) can be the stressful for staff involved. Another source of frustration for the staff may be the fact that these students make such slow, sometimes imperceptable or no progress. It is difficult to put one's total effort into something for a period of months and still see no change. Thus, the program recognizes the need for substantial staff support. Extra breaks are taken as needed after a difficult confrontation with a student. Weekly staff meetings including the educational supervisor, psychologist, classroom staff, and evening staff are held to discuss behavior plans, goals, schedules, problems, concerns, and progress. The educational supervisor and psychologist make an effort to spend time in the classroom each day. In-service was planned for the staff to increase skills necessary to work with this special group. Several training sessions were held to strengthen the staff's skills in observation and data-keeping. All of the staff participated in a 3-day technical training session on the management of aggressive and self-abusive individuals. The staff uses these techniques when necessary to manage the students according to the prescribed behavior plans. In addition several psychological consultants have been invited to provide input and suggestions to the group. These efforts to provide additional support form the initial steps to address the problem of staff "burnout", but we are still trying to come up with other possibilities in this area. Most likely, however, this issue can never be resolved to everyone's satisfaction.

Given the above-mentioned background and description of the program, I will recount the details of its set-up and implementation in chronological order using Joe's case as an example.

Although these students were not new to the school program, they were unfamiliar to most of the staff in the group. The first month or so consisted of setting up the classroom and planning an initial schedule on the basis of specific activities that the students had enjoyed in previous years. Reducing the demands and trying to discover activities which will motiviate the students is an important and perhaps unique aspect of the program.

During this initial set-up period, staff took note and informally observed students' negative behaviors after which time a comprehensive list of problem behaviors were formulated. (See Example I). This list included behaviors for all 6 students. Using this list as a practice sheet, pairs of staff practiced recording the behaviors. Following the observation period (usually ½ hour), the two staff observers compared their recorded data to check that each had recorded the behavior in the same manner.

By the beginning of November, the staff was very familiar with the student's individual behaviors through working with them and observing them. Individual behavior lists were written for each student. All staff had input into these lists from which the baselines were taken. An example of one student list is given in Example II.

Baselines were taken for a 1-week period, Monday - Friday, but not necessarily on consecutive days. We felt that it was important to record the beginning, middle and the end of the week, as well as a wide selection of activities both in the morning and the afternoon. Several different staff people worked with the students also. We wanted to have data on almost all possible variables in hopes of identifying a pattern of behavior which might be environmentally related. To insure accuracy two people recorded at all times including the psychologist and the educational supervisor.

The baseline data were reviewed by the whole group who then selected a single behavior on which to focus our attention in an effort to effect change. This decision was made on the basis of the severity and frequency of the behavior and according to the staff's personal feelings about its disruptive character and damage to the program. In Joe's case a "tantrum" behavior was selected. He had displayed what was called a "fit" or "tantrum" since his arrival at the Institute in 1976, but records state that the behavior also existed while in residence at a state institution. The "tantrum" begins with Joe standing, his body becomes very tense, elbows bent, he rocks the upper half of his body back and forth, throwing his head back while arching his back, almost as if he intended to complete a back flip.

These strong thrusts occur in quick succession. Often he will stop long enough to slap himself forcefully with an open palm on the back of his neck or side of his face, the sound of which can be heard down the hall. He usually makes a crying sound with no tears. The other part of the "tantrum" occurs on the floor where he writhes (as if in pain) and/or continues to arch his back and slap his face. One such tantrum lasted 4 hours at the group home where Joe resides, although a 2-hour tantrum is the longest recorded at the Institute. The October baseline (Example III) does not show the number of outbursts during the day, but the total number of times Joe slapped his face during a day. We chose to design a behavior plan to decrease this behavior because it could result in injury to Joe and was disruptive to the total program.

Although everyone was anxious and impatient to formulate some kind of strategy to deal with many of the students' problem behaviors, we did so only when we had gathered enough information and covered all preliminaries (See Example IV). In Joe's case, several neurological evaluations had been completed; and there was no indication that his "fits" or "tantrums" were seizure disorders, which are often present in the "rubella syndrome." For some students time did not allow all of the staff to participate in the development of the behavior plan, but Joe's plan was outlined in such a manner. I believe that the plans have more meaning and are followed more closely when all of the staff have input. We had looked carefully for some environmental or physiological factor for Joe's behavior by reviewing the data sheets and by observing him in the classroom.

Although there were times when a change in routine (dressing before breakfast) resulted in a "tantrum," this was not consistent. There were also times when a sudden approach or unusual handling may have created a "tantrum." Prior to the implementation of the behavior plan, staff had supposed that Joe's physiological needs were not met and had given him drinks of water or taken him to the bathroom at the onset of a "tantrum." Sometimes he stopped, and sometimes he didn't.

Therefore, the staff agreed that we should proceed with a plan based on the premise that Joe's "tantrums" were primarily attention-getting (See Example V). It was often extremely difficult for staff to stand and allow Joe to hit himself with such ferocity. In fact, sometimes staff had to be relieved when the situation became too intense.

The implementation of the behavior plan began the first of December. Although the "tantrums" were not eliminated, some changes have occurred in the character and quality of the behavior. "Tantrums" have generally decreased in duration and intensity, and a reduction in frequency has also been noted. At times Joe seems more aware of the presence of an adult. For example, at the onset of a "tantrum" he will sometimes attempt to reenter the room independently or may explore the hallway or other classrooms. During these times he may still be slapping himself and/or crying. But the fact that he explores or seeks out adults is a positive sign that he is coming out of his withdrawn, totally self-involved behavior. Once the "tantrum" ceases, Joe may grab at the adult and attempt to gouge or scratch, but this occurs less frequently. Often, Joe can be reengaged in an activity.

Unfortunately, however, the baselines that were taken first in October and then in March do not reflect the improvement in behavior that occured with Joe. When we took the baseline in October, he was slapping so much that we counted numbers of slaps. The slapping was more or less continuous. After the behavior program began, the slapping occurred less constantly but centered around isolated incidents. Therefore, to compare the 2 baselines by looking at number of slaps is misleading. (See Example III & VI). It appears from the baselines that his behavior has regressed since he slapped himself 361 times in March compared to 162 times in October. However, the slapping at other times during the day has ceased, which is not reflected in this data, and there are other weeks when the slapping is reduced to a total of 100-200 times for the week.

If any conclusion can be drawn at this point, it could be that there has been an improvement in Joe's behavior, but it is not as consistent and as marked as indicated following the implementation of the behavior plan. His "tantrums" have not and probably will not be totally eliminated, and he still has some very "bad" days as indicated by the March baseline. One positive outcome has been that he sometimes clings to the adult and he sometimes will get up following a "tantrum" and explore even though this is still not consistent.

In the past few months staff attention has been called to still another aspect of Joe's behavior: social/sexual development which must be identified as an important and often overlooked consideration for severely handicapped deaf/blind adolescents. Joe and some of the other male and female students are beginning to have feelings of sexual arousal but have not learned how to handle these feelings or how to satisfy them. So often, physical contacts such as touching, guiding, or interacting tactually (which is the only way to communicate with these students) unintentionally may sexually stimulate a student.

The student, being unable to appropriately direct or control his/her feelings may get aggressive or otherwise agitated, thus making any further tactile contact difficult.

Since the majority of multi-handicapped students have reached adolescence in the past 2-3 years, the muti-handicapped program as well as the Institute at large, are faced with a challenging problem: social/sexual development in the low-functioning multi-handicapped adolescent. The problems occurring in the special class, such as preoccupation and perseveration of masturbation, unsuccessful attempts to masturbate and reach climax, or desiring adult sexual contact are not unique to this group. Solutions are currently being sought and new ways of looking at programming are being explored. A sub-committee has been formed to discuss problems and propose solutions specific to the low-functioning population. Concepts such as "private" and "public" and "appropriate" and inappropriate" (from a curriculum by Jean Edwards) are being used as a framework to better identify and categorize students' behaviors. We are also trying to improve staff and parent attitudes and values regarding social/sexual education and will continue to develop more concrete guidelines which can be applied to programming.

Staff is learning that our expectations for these students cannot be high. In terms of behavior we must look at it over a period of time. One day's occurrence of many behavior problems does not indicate regression or failure. Likewise, a day with no problem does not necessarily mean success.

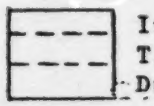
Everyone who works with this population must realize that no quick or simple solution to this problem exists. Given every advantage of staff, specialists, time, and money, a number of cloudy factors still remain, i.e. early sensory deprivation, sensory - neural dysfunction, and brain damage, the extent of which is unknown. So we must admit that we have not learned the causes of most of the behaviors of these students. We can only suspect that certain factors such as illness, the environment, sexual development, adolescence, ineffective communication, etc., contribute to or influence the students' behaviors. Since we cannot identify the reasons, we cannot expect to totally correct the behaviors. What we <u>can</u> do, however, is attempt to minimize them and perhaps to identify likely times when they might occur.

STUDENT'S NAME _____ DATE _____

CATEGORIES OF BEHAVIORS

DURATION

5 Behavior lasts from 30 minutes to 1 hour
4 Behavior lasts from 15 minutes to 30 minutes
3 Behavior lasts from 5 minutes to 15 minutes
2 Behavior lasts from 1 minute to 5 minutes
1 Behavior lasts from 1 minute or less



---	---	---	---	--	---	---	---	---	---	---	Slaps or strikes self
---	---	---	---	--	---	---	---	---	---	---	
---	---	---	---	--	---	---	---	---	---	---	Slaps or strikes others
---	---	---	---	--	---	---	---	---	---	---	
---	---	---	---	--	---	---	---	---	---	---	Kicks others
---	---	---	---	--	---	---	---	---	---	---	
---	---	---	---	--	---	---	---	---	---	---	Removes clothing at inappropriate time
---	---	---	---	--	---	---	---	---	---	---	
---	---	---	---	--	---	---	---	---	---	---	Tears own clothing
---	---	---	---	--	---	---	---	---	---	---	
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---	---	---	---	--	---	---	---	---	---	---	
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---	---	---	---	--	---	---	---	---	---	---	Destroys objects or toys
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---	---	---	---	--	---	---	---	---	---	---	Bangs _____ against_____
---	---	---	---	--	---	---	---	---	---	---	
---	---	---	---	--	---	---	---	---	---	---	Bites self
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---	---	---	---	--	---	---	---	---	---	---	Bites others
---	---	---	---	--	---	---	---	---	---	---	
---	---	---	---	--	---	---	---	---	---	---	Scratches others
---	---	---	---	--	---	---	---	---	---	---	

											Pinches others
											Scratches self
											Pinches self
											Throws self on floor
											Soils and smears self
											Regurgitates food
											Pulls other's hair
											Chokes others

Joe

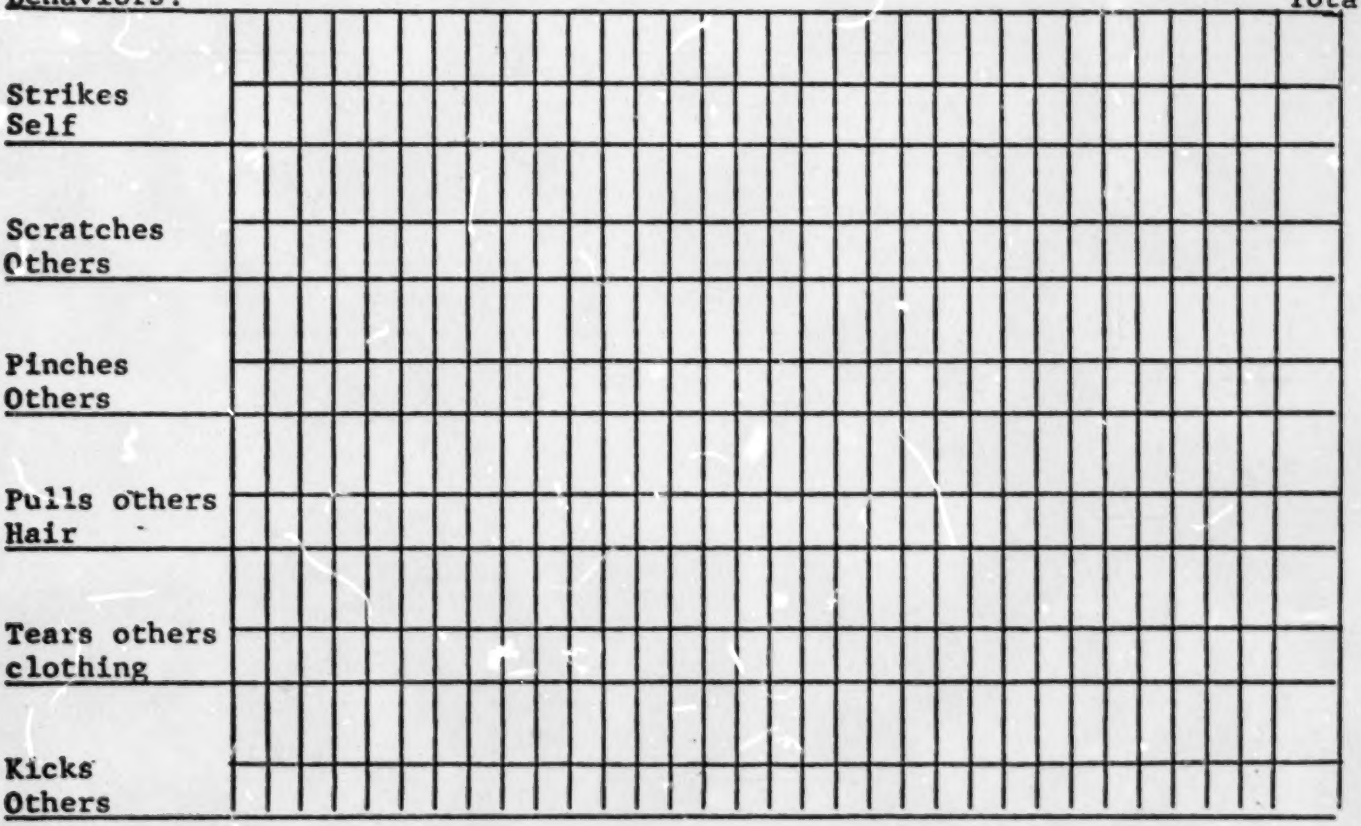
Name of Recorder:_____ Time Period (15 min.)_____

Activity:_____ Date:_____

Location of Activity:_____

Person working with student:_____

Behaviors: Total



COMMENTS:

October 8, 10, 16,
November 4, 24.

Baseline - 1 week

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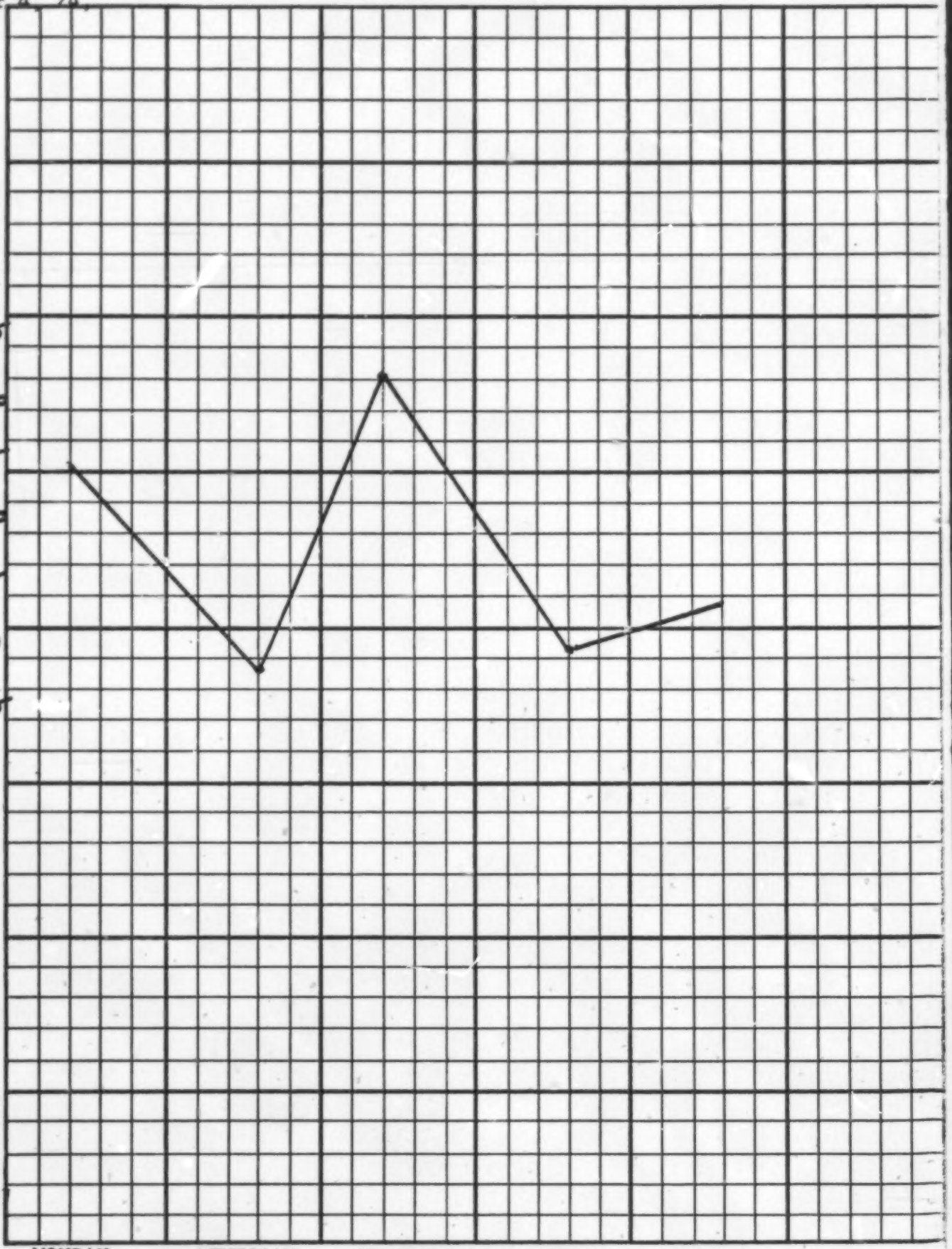
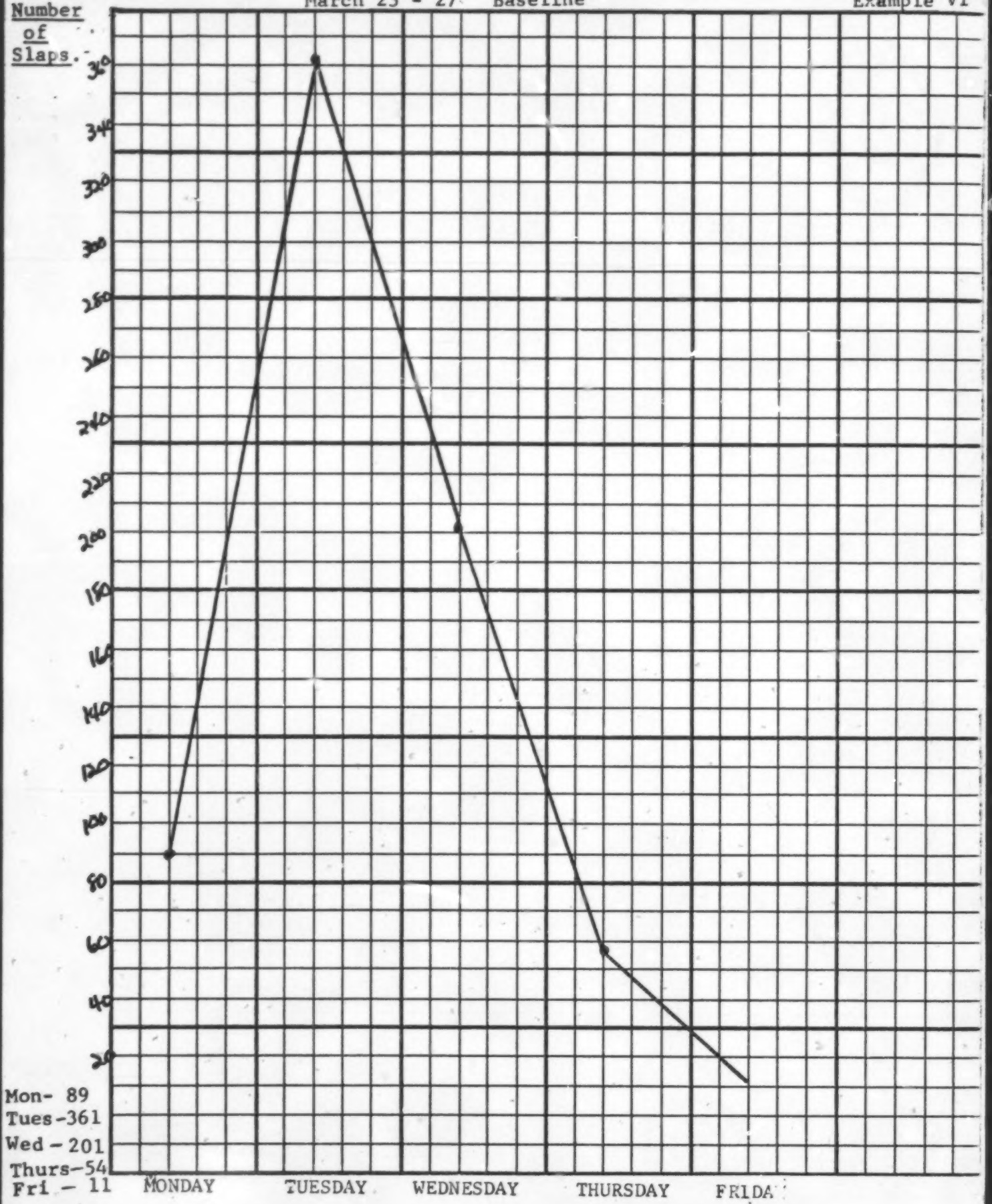


n.- 126
es.- 35
d. -162
urs.-42
i. - 57

March 23 - 27 Baseline

Example VI



Guidelines For Developing Behavior Plan

By Tom Miller, Amy Barnett Barash, Linda Gerra

I. Identify and define problem behavior.

II. Documentation of occurence and circumstances surrounding behavior.

III. Evaluate medical factors.

IV. Teacher, educational supervisor, and psychologist will interpret data, determine its meaning for student, and devise a behavioral plan.

V. Discuss and share plan with direct service staff, social worker and parent.

VI. Components of behavioral plan.

- A. Outline suspected reasons for behavior and rationale for specific intervention strategy.
- B. Formulate intervention strategies.
- C. Establish duration for behavioral plan.

VII. Monitor behavior during behavior plan. (collect data)

VIII. Review on-going program periodically.

IX. Evaluate effectiveness of plan.

REVISED TREATMENT PLAN FOR

JOE

In an attempt to eliminate Joe's tantrums a type of time out procedure has been devised. The theory behind this plan is that most of his tantrums are a form of communication. He may be communicating displeasure or frustration at a situation, the need for attention, or a want or need for something he is unable to express appropriately. Therefore, the following plan will be implemented during the school day beginning 12/11/80 for at least 2½ months. During the program, the frequency and length of time of any tantrums will be recorded daily.

1. PROCEDURE TO FOLLOW DURING A TANTRUM IS:

A. At the onset of the tantrum, remove him from the room or area. He should be placed outside the room or area and isolated from other children and staff. Since he will not injure himself on objects, he may be monitored by staff from inside the room.

B. No one is to interact with him during the tantrum.

C. Allow Joe to find his way back into the room. If he is still in the midst of a tantrum remove him again.

D. When the tantrum is over, either allow Joe to find his way back into the room or when he stops for about a minute or two and remains outside the area (use judgement to be sure the tantrum is over), wait at least one minute before bringing him back into the room.

E. If he was engaged in an activity when the tantrum began, resume it. If the tantrum begins again, follow the above procedure. When the tantrum ceases again, resume the activity. However the length of time to complete the activity may be shortened to a few minutes just so Joe will understand that a tantrum will not excuse him for completion of a task.

F. If Joe was not engaged in an activity when the tantrum began, allow him to do whatever he chooses.

G. This procedure must be followed whenever a tantrum occurs. Consistancy is crucial to the success of this program.

2. At times Joe may begin body movements (arching his back and jumping) which often signal the onset of a tantrum. However, sometimes he will begin laughing instead of hitting himself. When this occurs, reward this opposite sequence by physical contact and affection.

3. From baseline data is was noted that tantrums seem likely to

occur when Joe is expecting something and is made to wait. Therefore decrease the time Joe has to wait during various situations. For instance, have him get dressed last and do not seat him at the dining room table until he is ready to eat.

4. Increase positive experiences during the day. Watch for any expressive signs or communication and immediately respond to him.

5. For 15 minutes each day have a staff member sit next to him. Allow Joe to interact with the person on his terms or not at all. If he scratches, move away to show him this is an inappropriate interactions.

6. Since a tantrum may signal thirst or a need to be toileted increase opportunities for both during the day. This may be accomplished by following the IEP procedure and goals.

7. Every time Joe walks in and out of the classroom and other areas during his daily routine, have him trail the wall to facilitate learning. This will enable him to find his way back into a room independently.

Amy Barnett Barash, Psychologist
12/10/80